2007 Report to the Law Enforcement and Criminal Justice Interim Committee From the State Emergency Medical Services Committee As Required by 26-8a-103 (4)

Respectfully Submitted for Presentation at the November Interim Committee Meeting

Introduction

The Utah Emergency Medical Services System Act (Chapter 8a) requires the statutory Emergency Medical Services (EMS) Committee to submit an annual report each November to the Law Enforcement and Criminal Justice Interim Committee. The highest priorities are still cost, quality and access to EMS regarding the development of a comprehensive and integrated state EMS system. This report will focus on the following six issues and the effect they have on the statewide Emergency Medical Services system.

1. Appropriate providers for emergency medical services
2. Funding priorities and recommended sources
3. Closest responder recommendations
4. Centralized dispatch
5. Duplication of services and taxing consequences
6. Recommendations and suggested legislation

1. Appropriate Providers for Emergency Medical Services

Within the statewide EMS System, there are a total of 173 licensed and designated provider agencies serving every area of the state. The agencies are categorized as follow:

1. 119 Licensed ground ambulance and paramedic rescue agencies, and
2. 54 Designated quick response units providing various levels of pre-hospital care.

Resource Hospitals and Designated Trauma Centers: Within the statewide EMS system, the EMS Committee has designated all acute care hospitals and the VA hospital as resource hospitals. The 43 designated resource hospitals are committed to providing on-line medical direction and direct voice communications to EMS providers. Of those 43 facilities, seven hospitals have voluntarily met the extensive trauma center criteria and been designated as trauma centers by the Department of Health. They are:

1.	LDS Hospital	Level I
2.	Primary Children's Medical Center	Level I
3.	University of Utah Hospital	Level I
4.	McKay Dee Hospital	Level II
5.	Ogden Regional Medical Center	Level II
6.	Logan Regional Hospital	Level III
7.	Bear River Valley Hospital	Level IV

In addition to the above facilities, designation visits to the following facilities have been scheduled and will be completed by December 1, 2007: Intermountain Medical Center, Level I; Utah Valley Regional Medical Center, Level II; Dixie Regional Medical Center, Level III; Uinta Basin Medical Center, Level IV; Allen Memorial Hospital, Level IV. The Department of Health continues to work toward designation of the following rural hospitals: Sanpete Valley Hospital, Fillmore Medical Center, Delta Medical Center, Cache Valley Specialty Hospital, and Lakeview Hospital. Interest in becoming designated and initial conversations continues with Mountain West Hospital in Tooele.

Hospitals Participating in the Hospital Preparedness Program: In 2002, the Health Resource and Services Administration (HRSA), began a grant program designed to help hospitals and other healthcare entities to become more prepared for biological terrorism and other disasters. This grant has been managed within the bureau in partnership with the Utah Hospital Association, Association Community Health Clinics of Utah, Department of Human Services, Division of Information Technology, and other State/local agencies and partners. To date the program has grown to a total of 64 health care facilities. These facilities are categorized as follow:

Trauma Centers	7 (Includes 1 Pediatric Hospital)
Acute Care Hospitals	39
Pediatric Hospitals	1
Long Term Care/Rehab Hospitals	1
Psychiatric Hospitals/Facilities	2
Community Health Clinics	14
Tribal Health Systems	4

In addition to these facilities, the program will be adding 77 Skilled Nursing Facilities in 2008 and three additional long term care hospitals.

EMS Personnel: The EMS personnel affiliated with these licensed agencies are either part time paid or full time paid employees. There are four levels of certification for EMS personnel: EMT-Basic, EMT- Intermediate, EMT-Intermediate Advanced, and EMT-Paramedic. Each level has a specific scope of practice and hours of training:

EMT-Basic	120 hours
EMT-Intermediate	54 hours which include IV therapy, intubation and limited medications
EMT-Intermediate Advanced	competency based (approximately 600 hours)
EMT-Paramedic	1260 hours
EMD	24 hours

Service Levels: An applicant for licensure or designation can apply to provide any of the following levels of service. The list also includes the current number of licensed and designated providers within Utah at each level of service.

Transporting licensures:	
Basic Ambulance	11
Intermediate Ambulance	68
Intermediate Advanced Ambulance	2
Paramedic Ambulance	18
Air Ambulance	11
Non-transporting licensures:	
Paramedic Rescue	21
Non-transporting designations:	
Basic Quick Response Unit	38
Intermediate Quick Response Unit	16
EMS Dispatch agencies	52

Service Level Selection: The licensure level of a pre hospital EMS service provided by an ambulance is determined by local officials of the community being served. According to the Utah EMS Systems Act, 26-8a-403 (7) "The role of local governments in the licensing of ground ambulance and paramedic providers that serve areas also served by the local governments is important. The Legislature strongly encourages local governments to establish cost, quality and access goals for the ground and paramedic services that serve their areas."

New Licensed EMS Providers: The following agencies received a new license this year:

American Fork Fire Department	Paramedic Rescue

The following were re-licensed this year:

Uintah Basin Medical Center	Paramedic Ambulance
Uintah Basin Medical Center	Intermediate Ambulance
Mountain West	Paramedic Rescue
Midvale City	Paramedic Rescue
Midvale City	Paramedic Ambulance
Syracuse Fire Department	Intermediate Ambulance
Beaver Ambulance	Intermediate Ambulance
Clinton City Fire	Intermediate Ambulance
Saratoga Springs Fire Department	Intermediate Ambulance
Rockville/Springdale Fire Department	Intermediate Ambulance
Mountain West	Intermediate Ambulance
Orem Dept of Public Safety	Paramedic Ambulance
Kaysville City Fire Department	Intermediate Ambulance
South Ogden Fire Department	Intermediate Ambulance
Box Elder County	Intermediate Ambulance
Carbon County	Intermediate Advanced Ambulance
Enterprise	Intermediate Ambulance
Hildale City Fire Department	Paramedic Ambulance
Hurricane Fire and Rescue	Intermediate Ambulance

Iron County	Intermediate Ambulance
Morgan County	Intermediate Ambulance
North View Fire Department	Intermediate Ambulance
Ogden City Fire Department	Paramedic Rescue
Ogden City Fire Department	Basic Rescue
Ogden City Fire Department	Paramedic Ambulance
Roy Fire and Rescue	Basic Ambulance
San Juan EMS	Intermediate Inter-Facility
Weber County/Roy Fire Department	Paramedic Rescue
Weber County/Roy Fire Department	Paramedic Inter-Facility
Weber Fire District/Ogden Fire Department	Paramedic Ambulance
Weber Fire District	Basic ambulance

EMS Care Consistency: Whether in rural Utah or on the Wasatch Front, EMS personnel meet the same training and certification standards and stand ready to care for victims of injury or illness. Licensed ambulance providers throughout the state are required to have the same personnel, equipment, and operational standards. Through automatic aid agreements and local disaster plans, these licensed ambulance providers are in a constant state of readiness to serve the public. They are becoming even more skilled and prepared to deal with weapons of mass destruction and mass casualties from natural and human caused disasters.

Recruitment and Retention: Some rural services are having difficulty in recruiting and retaining personnel sufficient to maintain services. Continuous turn over of staff decreases the skill level of the service. The problem is most prominent in sub-frontier counties. The common problem is the inability to provide pay at a level to prevent migration to the larger markets. While lack of revenue due to low call volume and low income communities will always be a problem, many of the rural agencies are contributing to the problem through an unwillingness to charge for services at levels allowed by law or even at all. This is further limiting the revenue available to retain personnel. Several of the hardest hit areas experience a surge in calls during their respective tourist season, yet these counties or cities have not enacted taxation of the tourist population to support the infrastructure needs. The Bureau of EMS is working with the local agencies to encourage active funding of EMS.

Background Criminal Investigation Process: To be able to check on the juvenile records of potential Emergency Medical Technicians (EMT) the law needs to be changed to allow the Department to have access to the felony records of juvenile offenders. This is extremely important if the offense involved sexual or drug abuse or extreme violence. Vulnerable members of the public who receive services from EMTs can be better protected from individuals whose past criminal records would, if they were an adult, disqualify them from employment.

EMS Strike Teams: During the previous fiscal year, the Bureau set up six EMS Strike Teams. These teams consist of a mix of 12 Paramedics or EMTs. The teams would be deployed during a disaster from an unaffected are to the affected area. The teams can be deployed with a trailer or just personnel. The intended application would be to augment EMS staffing, hospital staffing, triage

center staffing, casualty collection points, or mass patient transportation support in an affected area. Each team is equipped with a trailer which contains medical supplies and equipment to manage up to 100 patients. An additional support trailer would be delivered to the team upon deployment that would sustain the team through a field deployment for 72 hours, with only food and water needed to extend the deployment. An additional three Strike Team trailers have been pre-positioned around the state for rapid re-supply and to support disaster response in those communities.

EMS POLARIS system: In 1994, the National EMS Information System (NEMSIS) data standard was published, and Utah was one of 52 states and territories to commit to adopt the standard in its prehospital data collection system. The Bureau created the Prehospital On-Line Active Reporting Information System (POLARIS) to replace the existing 20-year-old data collection system and implement the NEMSIS standard. POLARIS went live in September 2006. As of September 25, 2007, 54% of ground EMS agencies are reporting data to the Bureau using the new standard, and compliance with the data collection rule (R426-7) has nearly doubled in the past year. The Bureau is submitting a revision to R426-7 that will make the NEMSIS standard mandatory; the revision will soon enter the public comment phase of the process.

2. Funding Priorities and Recommended Sources

EMS Grants Program: In 1986, the Legislature created a funding mechanism to establish an EMS Grants program to help offset the lack of tax-based funding and federal aid for the improvement of the EMS system throughout the state. This program is funded by a dedicated source (criminal fines and forfeitures) which established grants for the improvement of the statewide emergency medical services system. The Department of Health receives an amount equal to 14% of the total amount accumulated through the criminal fines and forfeiture process.

By statute, the EMS grants program was divided into fund accounts. The Department may use funds for statewide staff support, administrative expenses, other department administrative costs under this chapter, and trauma system development. Fifteen percent is dedicated to funding high school emergency medical training programs. Of the remaining funds, 42.5% is allocated for per capita grants, and 42.5% for competitive grants to local EMS entities.

In FY 2006, the EMS program received $2.5 million for this program. This amount allowed the EMS Committee to distribute $1,100,000 through competitive grants, and $1,000,000 through per capita grants for a total of $2,100,000.

The Per Capita grants are determined by a point system. Each EMT is given a number of points for their level of certification:

Basic	=	2 points
Intermediate	=	3 points
Intermediate Advanced	=	3 points
Paramedic	=	4 points
EMD (dispatcher)	=	1 point

Certified personnel will receive per capita funding for only one agency per county. Agencies that

cover multiple counties will receive points for their personnel from the county where the certified person lives.

The Department contracted with the State Office of Education for the high school training program. A new program, called "What to Do When Every Minute Counts" was written by three Health Educators and pilot courses were held during FY2006. Also, four breakout sessions for health teachers were held to introduce them to the new program. A workbook for students and power point presentations for the teachers have been developed to use during their courses. The State Office of Education is also working with an EMS Coalition to have local EMS agencies provide the CPR portion of the courses. We are hoping that all 10th grade students will receive this program.

Emergency Medical Services for Children Outreach Initiatives: One of the goals of the National Emergency Medical Services for Children (EMSC) program is to establish permanence of EMSC in each State's EMS System. The National EMSC and HRSA program recommend that the EMSC Coordinator function as an integral staff member of the EMSC program with the state office of EMS. An EMSC coordinator position that is supported by non-federal funds is an indication that the EMSC program in the state is being sustained over the long term and achieving the desired outcome and providing access to healthcare for children. Funding is needed at the state level to support a full time EMSC coordinator. Utah has the nation's youngest population, and children account for 23.2% of EMS calls which is more than twice the national rate of 10%. Many EMS agencies in Utah are volunteer and operating at the EMS Basic and Intermediate levels. The need for pediatric prehospital education is significant for EMS providers due to the limited funding, time and availability of pediatric expertise at the local level. The Department of health has submitted a building block to request state funds to support this position. This building block will be submitted to the Governor and Legislature for consideration.

Rate Adjustments: The Department of Health conducted a study of the ambulance base rates. The study evaluated the current base rates and assessed the provider revenues needed to achieve an adequate return. The Department authorized a 3.2 % maximum base rate increase order which took effect on July 1, 2007. This increase was necessary to offset the impact of inflation, fuel costs and was identical to the CPI average for FY 2007. Additionally, the rates rule was amended to add a fuel fluctuation fee that will allow for immediate corrections to the mileage rate during periods of rapid increases in fuel prices. The fee will occur in $.25 after a predetermined threshold has been reached and only on administrative order from the Bureau. The amendments addressed non-transport rates defining the service and setting the conditions to be met in order to charge the fee, and setting the maximum rate. The off-road surcharge was completely restructured to $1.50 per mile of off-road travel after the first 10 miles. This replaced the old flat fee of $39.75 for off-road travel.

3. Closest Responder Recommendations

The EMS law clearly identifies that each provider be licensed for an exclusive geographical service area with aid agreements in place to allow for response when they are not available. This system takes into consideration at the time of licensure and re-licensure that the most appropriate responder is licensed for the exclusive geographical area. There is no consideration in the statute or rules that allows for the current location of a responder to be the determining factor.

4. Centralized Dispatch

Dispatch Task Force: A task force consisting of representatives from the Fire Service, Sheriffs Association, Police Chiefs Association, and Communications Managers met to propose new guidelines for dispatch designation and rule changes. The group came to a consensus that there should be three levels of dispatch designation: basic, intermediate, and advanced. Each center would be inspected by the Department every year and re-designated every four years. The task force also requested the Department provide a list of approved dispatch card systems, provide initial training for dispatchers, and allow the dispatch centers to fingerprint their own dispatchers as required for certification. The process is now in the final stages of implementation and rules are being approved to address the recommended changes.

Impact on EMS: These recommendations will have a positive impact on EMS statewide since it will allow all dispatch centers to be designated at a level that matches the level of service provided. It will also increase the number of training opportunities available for dispatchers to receive initial training at a reduced cost to the centers. The most positive outcome from this process was a unified voice from the Fire, Sheriff, Police Associations, and Dispatch Managers on a proposal that will improve the system for all dispatch agencies.

5. Duplication of Services and Taxing Consequences

Since the law requires exclusive geographic service areas and does not allow overlapping, there is no duplication of services in the emergency response area, and therefore, no taxing consequence. Where there is a "Request for Proposal" license there are always two providers for the same area, one providing 911 services and one providing non-911 services. This is not duplication because the 911 provider does not provide non-911 services and vice versa.

6. Recommended and Suggested Legislation

An issue that continues to affect rural ambulance services is access to patients that are injured or become ill in remote areas of the state. This is further complicated by the access or lack of access to rural roads. Since this is an issue that is before the Legislature and has many varied responses, it is our intent that the EMS component not be forgotten in the discussions of access.

Conclusion

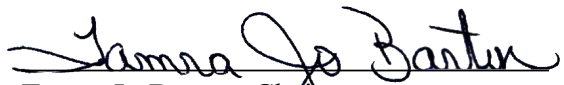
The same conclusion as mentioned last year is even more applicable this year. The State EMS Committee continues to believe that essential stable funding sources be implemented to assist all local EMS providers in managing the increasing demands of the citizens. These EMS providers are in a constant state of readiness to meet the needs of patients regardless of their ability to pay. As the EMS Committee considers decisions affecting EMS providers and the public, cost, quality, and access will continue to be the major considerations.

Over the past few years, a strong statewide effort has been made to educate and equip EMS providers and hospitals with the necessary tools to respond to natural or human caused disasters. With an ever changing world around us and the unknown status of terrorism or disasters, security and disaster preparedness has recognized EMS providers as first responders and hospitals as first receivers. This clearly identifies them as a significant link between the victims of injury or illness and the health care delivery system. Additional efforts will be made with EMS providers and hospitals to encourage them to continue to work closely with local law enforcement, health departments, community leaders, encourage holding exercises, integrate, and update their disaster response plans, including surge capacity, and contingency plans.

The recent completion of the Statewide Public Health Emergency Response Exercise (SPHERE) held September 18-20, was a tremendous opportunity for the Bureau of EMS and Utah's public health system to test its preparedness capabilities statewide. This functional exercise presented a mock pandemic influenza disaster leaving over 50,000 ill within its first week in Utah, 8,000 needing hospitalization, and over 700 dead. Statewide, 16 separate venues of play participated in this coordinated effort to track and mitigate the problem. Agencies included the Utah Department of Health, the state EOC (Homeland Security), all 12 of Utah's local health departments, the Utah Navajo Health Systems Montezuma Creek Clinic, and the Utah Public Health Laboratory. In addition, several state and local response partners assisted these venues in the response, including federal representatives, other state agencies, the Utah National Guard, local emergency management and others.

Utah has an EMS system with oversight and responsibility for delivery of emergency medical services from the originating 911 call for help to the delivery of the patient to the appropriate patient receiving facility. This system is enhanced and the safety of the users of the system improved as all parties work together in a unified approach to problems, thus assuring the public of a safe and efficient system. The EMS Committee plays a vital role in the oversight of the system and is proud of the working relationship between the Bureau of EMS, all provides, and the citizens of the state.

Respectfully,



Tamra Jo Barton, Chairperson
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[i] 2007 legislative report, Oct 16